OF CORRECTION	IDENTIFICATION NUMBER:					
	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155245		NG	00	COMPLI	
133243		B. WING			07/12/	2012
ROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP CODE		
ON HEALTH CAR	E CENTER					
SUMMARY S	TATEMENT OF DEFICIENCIES	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)
*				CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
REGULATORY OR	LISC IDENTIFYING INFORMATION)	T.	AG	DEFICIENCY)		DATE
This visit was f State Licensurincluded Invest IN00110834. Complaint IN00 Substantiated. related to the a Survey dates: July 9, 10, 11, Facility number Provider numb AIM Number: Survey team: Lora Brettnach Connie Landm Diana Zgonc, F Christi Davidso Census bed typ SNF/NF: 59 Total: 59 Census payor Medicare: 10	or a Recertification and e Survey. This visit tigation of Complaint  0110834 - No deficiencies allegation(s) are cited.  & 12, 2012  r: 000149 er: 155245 100266840  er, RN-TC an, RN RN on, RN on, RN		AG		TE	DATE
Total: 59						
	SUMMARY S (EACH DEFICIENT REGULATORY OR State Licensure included Investing IN00110834.  Complaint IN00 Substantiated. related to the assured to the assured for the assured for the substantiated for the assured for the substantiated. Survey dates: July 9, 10, 11, Facility number Provider numb AIM Number:  Survey team: Lora Brettnach Connie Landm Diana Zgonc, Fachristi Davidson Census bed type SNF/NF: 59 Total: 59 Census payor:	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  This visit was for a Recertification and State Licensure Survey. This visit included Investigation of Complaint IN00110834.  Complaint IN00110834 - Substantiated. No deficiencies related to the allegation(s) are cited.  Survey dates: July 9, 10, 11, & 12, 2012  Facility number: 000149 Provider number: 155245 AIM Number: 100266840  Survey team: Lora Brettnacher, RN-TC Connie Landman, RN Diana Zgonc, RN Christi Davidson, RN  Census bed type: SNF/NF: 59 Total: 59  Census payor type: Medicare: 10 Medicaid: 39 Other: 10	OVIDER OR SUPPLIER ON HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  This visit was for a Recertification and State Licensure Survey. This visit included Investigation of Complaint IN00110834.  Complaint IN00110834 - Substantiated. No deficiencies related to the allegation(s) are cited.  Survey dates: July 9, 10, 11, & 12, 2012  Facility number: 000149 Provider number: 155245 AIM Number: 100266840  Survey team: Lora Brettnacher, RN-TC Connie Landman, RN Diana Zgonc, RN Christi Davidson, RN  Census bed type: SNF/NF: 59 Total: 59  Census payor type: Medicare: 10 Medicaid: 39 Other: 10	ONTIDER OR SUPPLIER ON HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  This visit was for a Recertification and State Licensure Survey. This visit included Investigation of Complaint IN00110834.  Complaint IN00110834 - Substantiated. No deficiencies related to the allegation(s) are cited.  Survey dates: July 9, 10, 11, & 12, 2012  Facility number: 000149 Provider number: 155245 AIM Number: 100266840  Survey team: Lora Brettnacher, RN-TC Connie Landman, RN Diana Zgonc, RN Christi Davidson, RN  Census bed type: SNF/NF: 59 Total: 59  Census payor type: Medicare: 10 Medicaid: 39 Other: 10	ONDER OR SUPPLIER  ON HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  This visit was for a Recertification and State Licensure Survey. This visit included Investigation of Complaint IN00110834.  Complaint IN00110834 - Substantiated. No deficiencies related to the allegation(s) are cited.  Survey dates: July 9, 10, 11, & 12, 2012  Facility number: 100266840  Survey team: Lora Brettnacher, RN-TC Connie Landman, RN Diana Zgonc, RN Christi Davidson, RN  Census bed type: SNF/NF: 59 Total: 59  Census payor type: Medicare: 10	ONDER ON SUPPLIER  ON HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  This visit was for a Recertification and State Licensure Survey. This visit included Investigation of Complaint IN00110834.  Complaint IN00110834 - Substantiated. No deficiencies related to the allegation(s) are cited.  Survey dates: July 9, 10, 11, & 12, 2012  Facility number: 000149 Provider number: 155245 AIM Number: 100266840  Survey team: Lora Brettnacher, RN-TC Connie Landman, RN Diana Zgonc, RN Christi Davidson, RN  Census bed type: SNF/NF: 59 Total: 59  Census payor type: Medicare: 10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000149

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

(X6) DATE

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/06/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155245	A. BUILDING B. WING		07/12/2012
NAME OF F				ADDRESS, CITY, STATE, ZIP CODE	
	PROVIDER OR SUPPLIEF			86TH ST	
CASTLE	TON HEALTH CAR	E CENTER	INDIAN	IAPOLIS, IN 46256	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
1710		cies reflect state	1710		BATE
		n accordance with 410			
	17.00 10.2.				
	Quality review 2012 by Bev F	completed on July 17,			
	2012 by BCV1	adikilor, ixiv			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5ECN11

Facility ID: 000149

If continuation sheet Page 2 of 10

STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155245	B. WING			07/12/	2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			7630 E	86TH ST		
	TON HEALTH CAR	E CENTER		INDIAN	IAPOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0371	483.35(i)						
SS=E	FOOD PROCUR	RE/SERVE - SANITARY					
	The facility must						
	•	from sources approved or					
	` '	factory by Federal, State or					
	local authorities;						
	(2) Store, prepar under sanitary co	e, distribute and serve food onditions					
	Based on obse	rvation, interview and	F03	71	What corrective action(s) will I		08/02/2012
	record review, t	the facility failed to			accomplished for those reside		
	ensure proper l	kitchen hand washing			found to have been affected by	/	
	and failed to en	sure proper hand			the deficient practice; It is the policy of this facility to ensure		
		en serving resident			proper kitchen hand washing a	and	
	_	ch had the potential to			to ensure proper hand washing		
		residents that receive			between serving resident mea	I	
	meal travs from	the kitchen. (Cook			trays. Cook #1 has been		
		PN [Licensed Practical			in-serviced to use a dry paper towel to dry hands. Then use		
		[Activity Aide] #4, RNA			another dry paper towel to turn	off	
	[Restorative Nu				hand washing sink faucet after		
	- ·	fied Nursing Aide] #6)			washing hands. Cook #2 has		
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	.oa (tarog /ao] //o/			been in-service as to wheneve		
	Findings includ	۵.			he leaves the serving line to w his hands prior to stepping bac		
	l mango molaa	<b>o</b> .			on line. LPN #3 has been	, N	
	l 1 During a kito	chen observation on			educated as not to butter		
	7/9/12 at 11:16				resident's bread using her bare	<del>)</del>	
		ands in one of the			hands. LPN #3 has also been		
					educated as to use hand gel		
		ashing sinks and was			between resident's meal trays.  AA#4 has been educated as to		
		ng the water faucet off			use hand gel after touching a	,	
		nd and then dried their			resident or putting a clothing		
	hands with pap	er towei.			protector on a resident prior to		
					touching another resident. RN		
	_	chen observation on			#5 has also been educated to	use	
		a.m., Cook #2 left the			hand gel in between passing	hae	
		e, went to the back of			residents meal trays. CNA #6 lbeen educated to use had gel		
	the kitchen, we	nt into the dry storage			between resident to resident		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5ECN11

Facility ID: 000149

If continuation sheet Page 3 of 10

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, pull phic	00	COMPLETED	
		155245	A. BUILDING B. WING		07/12/2012	
				EET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	₹		DE 86TH ST		
CASTLE	TON HEALTH CAR	E CENTED		IANAPOLIS, IN 46256		
	- TON TILALITI CAN	E CENTER	I IND	TANAI OLIO, IIV 40230		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX		ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	
TAG		LSC IDENTIFYING INFORMATION)	TAG			
		rned to the food		contact. The ADON was also reminded that she should us		
		hout washing hands.		gel in between resident to	e nau	
	Cook #2 was o	bserved placing covers		resident contact. How other		
	on plates, addi	ng butter pats to trays,		residents having the potentia	al to	
	adding ice crea	am cups to trays and		be affected by the same def		
	adding milk car	rtons to trays.		practice will be identified and	<b>I</b>	
		-		what corrective action(s) will		
	During an inter	view on 7/9/12 at		taken. All residents have the		
	_	Dietary Manager		potential to be affected by the practice. The DON or design		
		aucet should be turned		will monitor each dining roor		
		r towel, and Cook #2		times weekly to ensure that	* * *	
		ashed hands when		staff are using proper hand		
				washing or hand gel in betw		
	returning to the	e food service line.		resident meal trays. Also the	;	
				Dietary manager will		
	_	ning observation on		monitor weekly (3) meal times "Food line production"	from	
		a.m., LPN #3 touched		beginning to end" to ensure	IIOIII	
		ce of bread with bare		proper hand washing with st	aff.	
	hands then pro	ceeded to serve other		What measures will be put in		
	residents' mea	I trays in the main		place or what systemic chan	ges	
	dining area wit	hout washing hands or		will be made to ensure that t	<b>I</b>	
	using hand gel	. LPN #3 removed		deficient practice does not re	· · · · · · · · · · · · · · · · · · ·	
	plastic wraps fi	rom cake, removed lids		At an all staff in-service held July 31, 2012 the proper	on	
		a resident's sandwich		techniques of hand washing	and	
		lding the knife in one		using hand gel while providi		
		andwich in the other,		resident assistance at meal	-	
		dent's potatoes, and		was discuss. Also meal tray	line	
		ing residents' meal		serving when leaving the foo		
		ashing hands or using		you must wash your hands u		
	1 -	•		returned was discussed. Any who fail to follow the outlined		
	_	een tasks in the main		in-service will be progressive	<b>I</b>	
	_	ixteen (6) residents		disciplined up to and including	· I	
		in the main dining		termination. How the correct	-	
		nch meal. A hand gel		action(s) will be monitored to	<b>I</b>	
	-	observed on the wall		ensure the deficient practice	will	
		then next to where the		not recur, i.e., what quality	,	
	tray cart was p	arked that contained		assurance program will be p	ut	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5ECN11

Facility ID: 000149

If continuation sheet

Page 4 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A RIII	LDING	00	COMPL	ETED	
		155245	B. WIN			07/12/	2012	
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF F	PROVIDER OR SUPPLIE	₹			86TH ST			
CVSTIE	TON HEALTH CAR	E CENTED			APOLIS, IN 46256			
CASTLE	TONTIEALTH CAN	LE CENTER		INDIAN	AFOLIS, IN 40250			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	residents' mea	l trays.			into place: and by what date th	ne		
					systemic changes will be			
	4. During a dir	ning observation on			completed. At the monthly qua	ality		
		is a.m., AA #4 put a			assurance meeting all	_		
		tor on a resident, then			monitoring(s) of resident meals and food line serving will be	S		
					discuss. Any negative patterns	3		
	•	erve other residents'			from the findings the	,		
		ne main dining area			Administrator shall appoint a			
		g hands or using hand			quality review team to follow u	ntil		
		up a resident's meat			100% compliance is met.			
	and continued	to serve multiple						
	resident trays v	without washing hands						
	or using hand	gel. Sixteen (16)						
		observed in the main						
		the lunch meal. A						
		nser was observed on						
		e the kitchen next to						
		cart was parked that						
	contained resid	dents' meal trays.						
	5. During a di	ning observation on						
	7/9/12 at 11:35	a.m., RNA #5 cut up						
	a resident's me	eat, rubbed a resident's						
		eeded to serve other						
		I trays in the main						
		•						
		hout washing hands or						
	using hand gel	` ,						
		observed in the main						
	_	the lunch meal. A						
	hand gel dispe	nser was observed on						
	the wall outside	e the kitchen next to						
	where the trav	cart was parked that						
	1	dents' meal trays.						
	35304 10010		1					
	6 During a gri							
	1	ning observation in the						
	∣ Main Dining Ro	oom on 7/9/12 at 11:40						

i i			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE :	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155245	B. WINC	·		07/12/	2012
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
040715	TON 11541 TH OAD	E OFNITED			86TH ST		
CASTLE	TON HEALTH CAR	E CENTER		INDIAN	APOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	BEFELECT		DATE
	A.M., CNA (Ce	_					
	l '	ssisted a resident with					
		od, rubbed another					
		, buttered another					
		d, helped another nwrapping their					
		sed drinks to another					
		the paper covers off					
	the lids. During						
	1	IA #6 did not wash or					
		nds between resident					
		tact. During this dining					
		e ADON (Assistant					
		sing) assisted a					
		eir clothing protector,					
		resident's arm, shook					
	·	nt's hand, then put					
		er resident's coffee.					
		not wash or sanitize					
	her hands betw	een resident to					
	resident contac	ct. The hand gel					
	container was	observed hanging on					
	the wall in the I	Main Dining Room.					
	A current policy	/ titled "Handwashing					
	Procedure" pro	vided by the ADON					
	(Assistant Dire	ctor of Nursing) on					
	7/11/2012 at 4:	34 P.M. was reviewed					
		t 3:15 P.M. This policy					
		dwashing was the					
		portant measure for					
	ı ·	spread of illness and					
		should wash his/her					
	1	after each direct					
	resident contac	ct (as indicated by					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5ECN11

Facility ID: 000149

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/06/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155245  NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256  (X5) PREFIX (EACH OEFICIENCY MUST BE PERCEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE DATE)  COMPLETED 07/12/2012  STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256  (X5) PREFIX (EACH OEFICIENCY MUST BE PERCEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE DATE)  COMPLETION DEFICIENCY)  DATE	
NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  7630 E 86TH ST  INDIANAPOLIS, IN 46256  (X5)  PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE	
CASTLETON HEALTH CARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE  (X5)  PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  (X5)  COMPLETION DEFICIENCY  DATE	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG DEFICIENCY  COMPLETION DATE	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE	т
	l
after handling contaminated articles	
. instances when hand washing	
should be done included before and	
after caring for each patient and	
before returning to the tray-line if you leave the tray-line. The policy further	
indicated staff should remember	
when a resident's body is weakened	
by illness of any kind, even his/her	
own germs can be a danger to	
him/her. It is their responsibility to	
minimize the spread of germs in the	
nursing facility by keeping the resident and his/her surroundings and	
yourself as clean and free of germs	
as possible".	
3.1-21(i)(3)	

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Event ID: 5ECN11

Facility ID: 000149

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION  00	(X3) DATE COMPL		
		155245	A. BUILDING B. WING	-	07/12	/2012
	PROVIDER OR SUPPLIER		STRE 7630	EET ADDRESS, CITY, STATE, ZIP CO 0 E 86TH ST IANAPOLIS, IN 46256	DDE	
						(W.5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F0441 SS=D	483.65 INFECTION COI SPREAD, LINEN The facility must Infection Control provide a safe, s environment and development and and infection.  (a) Infection Con The facility must Control Program (1) Investigates, infections in the (2) Decides wha isolation, should resident; and (3) Maintains a r corrective action  (b) Preventing S (1) When the Infedetermines that prevent the spre must isolate the (2) The facility m communicable d lesions from dire their food, if dire disease. (3) The facility m hands after each	establish and maintain an Program designed to anitary and comfortable to help prevent the ditransmission of disease trol Program establish an Infection under which it - controls, and prevents facility; to procedures, such as be applied to an individual ecord of incidents and is related to infections.  Pread of Infection ection Control Program a resident needs isolation to ad of infection, the facility resident.  Lust prohibit employees with a disease or infected skin ct contact with residents or extraordiction contact will transmit the lust require staff to wash their in direct resident contact for hing is indicated by accepted	TAG	DEFICIENCY)		DATE
	transport linens of infection.	handle, store, process and so as to prevent the spread	F0441		<b>.</b>	00/02/2012
		rvation, interview and the facility failed to	F0441	What corrective action(s accomplished for those		08/02/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5ECN11

Facility ID: 000149

If continuation sheet

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AN OF CORRECTION IDENTIFICATION NUMBER:		A. BUIL	DING	00	COMPLETED	
		155245	B. WING			07/12/2012	
			b. WIIW		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			86TH ST		
CASTLE	TON HEALTH CAR	E CENTER			APOLIS, IN 46256		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	ensure proper	hand washing during a			found to have been affected by	· I	
	medication pas	ss for 1 of 10 residents			the deficient practice; RN #7 a		
	observed for m	edication			RN #8 were both re-educated		
	administration.	Resident # 46.			the hand washing policy and to wash their hand prior and after		
					giving resident care. Resident	<b> </b>	
	Findings includ	۵۰			#46 had no adverse reaction to		
		ic.			the lack of their hand washing.		
	During a medic	cation observation on			How other residents having the		
	_	5 a.m., RN [Registered			potential to be affected by the		
					same deficient practice will be		
	_	RN #8 did not wash			identified and what corrective		
	•	on entering Resident			action(s) will be taken; All residents have the potential to	he	
		N #7 and RN #8			affected by this practice. The	De	
	_	. RN #7 stopped the			DON or designee will monitor		
	enteral feeding	s. RN #7 checked the			LPN/RN/CNA three times wee	kly	
	feeding tube fo	r residual contents.			monitoring each shift at least		
	RN #7 spilled t	he crushed			once to ensure proper hand		
	medications that	at were mixed in water.			washing is taking place accord		
	RN #7 cleaned	up the spilled			to the hand washing policy. W		
		dministered the liquid			measures will be put into place what systemic changes will be	<b> </b>	
		nd then capped the			made to ensure that the deficie	<b> </b>	
		RN #8 was instructing			practice does not recur; At an		
	_	procedure. RN #7 and			staff in-service held July 31, 20		
	· ·	their gloves and exited			the Hand Washing Policy and		
		•			Procedure was reviewed. Any	,	
		room without washing			staff who fail to follow the Han		
		using hand gel. RN #7			Washing Policy and Procedure	<b> </b>	
	•	the medication cart the			will be progressively discipline up to and including termination		
		at were spilled. RN #7			How the corrective action(s) w		
	and RN #8 re-e	entered Resident #46's			be monitored to ensure the		
	room and donn	ned gloves without			deficient practice will not recur	,	
	washing their h	nands or using hand			iel, what quality assurance		
	gel. RN #7 adı	ministered the crushed			program will be put into place;	<b> </b>	
	_	way of the feeding			the monthly quality assurance		
	tube.	,			meeting all monitoring from the	<b> </b>	
					hand washing observations wi be reviewed. Any negative	11	
	During an inter	view on 7/11/12 at			patterns will be discuss. If		
	_ = = = = = = = = = = = = = = = = = = =				pattorno wiii bo dioddo. II		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULT	TIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	00	COMPL	ETED
		155245	B. WING			07/12/	2012
			S	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	R	7	7630 E	86TH ST		
CASTLE	TON HEALTH CAR	RE CENTER	1	NDIAN	APOLIS, IN 46256		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	7	ΓAG	DEFICIENCY)		DATE
	11:00 a.m., RN	I #7 and RN #8			necessary the Administrator sh		
	indicated they	should have washed			appoint a quality review team t		
	their hands up	on entering and exiting			monitor until 100% compliance his reached.	9	
	Resident #46's	room.			nis reached.		
	During an inter	view on 7/11/12 at					
	_	ADON was requested					
	•	licy on hand washing,					
	1	she would expect staff					
		ands when entering or					
	exiting a reside	•					
	A facility policy	provided by the ADON					
		4:34 p.m., indicated,					
		ng is the single most					
		sure for preventing the					
		ssThe employee					
	l .	is/her hands routinely					
		ct resident contact (as					
		•					
	1	ccepted professional					
	practice) and a	•					
		articles4. Before and					
	_	each patient12.)					
	_	(sic) gloves on, and in					
	between puttin	g New (sic) gloves on."					
	0.4.40%						
	3.1-18(I)						

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